Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Dwayne Marrott

Respondent Name
Cherokee Insurance Co

MFDR Tracking Number
M4-13-1400-01

Carrier's Austin Representative
Box Number 16

MFDR Date Received
February 1, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "TWCC guidelines were followed. Billing was done under the global code 97799-CP as designated under TWCC Medical Fee Guideline procedures. There are no other CPT codes when billing for a chronic pain management program."

Amount in Dispute: $16,000.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Written acknowledgement of medical fee dispute received however, no written response submitted.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 16, 2012	97799-CP	$800.00	$16,000.00
January 17, 2012	97799-CP	$800.00	
January 18, 2012	97799-CP	$800.00	
January 19, 2012	97799-CP	$800.00	
January 20, 2012	97799-CP	$800.00	
January 23, 2012	97799-CP	$800.00	
January 24, 2012	97799-CP	$800.00	
January 25, 2012	97799-CP	$800.00	
January 26, 2012	97799-CP	$800.00	
January 27, 2012	97799-CP	$800.00	
February 2, 2012	97799-CP	$800.00	
February 3, 2012	97799-CP	$800.00	
February 7, 2012	97799-CP	$800.00	
February 8, 2012	97799-CP	$800.00	
February 9, 2012	97799-CP	$800.00	
February 13, 2012	97799-CP	$800.00	
February 14, 2012	97799-CP	$800.00	
February 15, 2012	97799-CP	$800.00	
February 16, 2012	97799-CP	$800.00	
February 17, 2012	97799-CP	$800.00	

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.202 sets out medical fee guidelines for professional medical services provided in the Texas Workers' Compensation system.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - Allowance is based on Usual & Customary Fee Schedules

Issues

1. Did the respondent support reduction in payment of disputed services?
2. Is the requestor entitled to reimbursement?

Findings

1. Carrier reduced the services in dispute as "Allowance is based on Usual & Customary Fee Schedules." Per 28 Texas Administrative Code §134.202(5)(E) states:
   - "Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs
     (i) Program shall be billed and reimbursed using the "Unlisted physical medicine/rehabilitation service or procedure" CPT code with modifier "CP" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited Programs shall add "CA" as a second modifier.
     (ii) Reimbursement shall be $125.00 per hour. Units of less than 1 hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to 8 minutes and less than 23 minutes."

   Review of the submitted documentation finds the medical claims were submitted in compliance with applicable Division rules and guidelines however, the reimbursement from the carrier is not. The Maximum Allowable Reimbursement (MAR) will be calculated per applicable rules and guidelines.

Date of Service	CPT Code	Units	MAR	Amount Paid	Additional Payment Due
January 16, 2012	97799-CP	8	$125 x 8 = $1,000	$200.00	$800.00
January 17, 2012	97799-CP	8	$125 x 8 = $1,000	$200.00	$800.00
January 18, 2012	97799-CP	8	$125 x 8 = $1,000	$200.00	$800.00
January 19, 2012	97799-CP	8	$125 x 8 = $1,000	$200.00	$800.00
January 20, 2012	97799-CP	8	$125 x 8 = $1,000	$200.00	$800.00
January 23, 2012	97799-CP	8	$125 x 8 = $1,000	$200.00	$800.00
January 24, 2012	97799-CP	8	$125 x 8 = $1,000	$200.00	$800.00
January 25, 2012	97799-CP	8	$125 x 8 = $1,000	$200.00	$800.00
January 26, 2012	97799-CP	8	$125 x 8 = $1,000	$200.00	$800.00
January 27, 2012	97799-CP	8	$125 x 8 = $1,000	$200.00	$800.00
February 2, 2012	97799-CP	8	$125 x 8 = $1,000	$200.00	$800.00
February 3, 2012	97799-CP	8	$125 x 8 = $1,000	$200.00	$800.00
February 7, 2012	97799-CP	8	$125 x 8 = $1,000	$200.00	$800.00
February 8, 2012	97799-CP	8	$125 x 8 = $1,000	$200.00	$800.00
February 9, 2012	97799-CP	8	$125 x 8 = $1,000	$200.00	$800.00
February 13, 2012	97799-CP	8	$125 x 8 = $1,000	$200.00	$800.00
February 14, 2012	97799-CP	8	$125 x 8 = $1,000	$200.00	$800.00
February 15, 2012	97799-CP	8	$125 x 8 = $1,000	$200.00	$800.00
February 16, 2012	97799-CP	8	$125 x 8 = $1,000	$200.00	$800.00
February 17, 2012	97799-CP	8	$125 x 8 = $1,000	$200.00	$800.00
		TOTAL	$20,000.00	$4,000.00	$16,000.00

2. The total allowed amount for these services is $20,000.00. The previous payment by the carrier is $4,000 leaving a balance of $16,000.00. The requestor is seeking $16,000.00 this amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $16,000.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $16,000.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May , 2014 Date
Signature	Medical Fee Dispute Resolution Manager	May , 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.